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## CEREBRAL - PALSIED CHILDREN ATTEND SPECIAL

**HELEN M. WALLACE, M.D.  
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**U**NTIL RECENT YEARS most children with cerebral palsy have been considered by the public uneducable and more or less incapable of becoming independent adults able to care for themselves. Few communities have provided special facilities and personnel for their care and education. These children have thus often been neglected and left to fend for themselves as best they could, with the result that for the most part they have been uneducated, untrained, and more or less even unable to care for their daily needs. Ultimately many of them become a permanent burden to society.

Experience, however, has shown, over the past two decades particularly, that habilitation of many of these children is possible.

More recently, organized groups of parents of children with cerebral palsy have done much to promote community activities for these children. They have raised funds to provide special care for their children, have helped to promote research, have allocated funds for the training of personnel, and have worked toward enactment of legislation appropriating

public funds so that more adequate services may be provided for such children.

Many kinds of health and education services are being developed to meet the differing needs of cerebral-palsied children.

The health services include: Diagnostic and treatment services on an out-patient basis; in-patient hospital care; in-patient convalescent and rehabilitation care; care at residential schools; and institutional care for children who are severely retarded in mentality.

### Cerebral-palsied receive instruction

As for the schooling of the cerebral-palsied children, some of those in New York City attend public-school classes for various kinds of orthopedically handicapped children—some of them cerebral-palsied. Still others are in public-school classes for various kinds of mentally retarded children, including the cerebral-palsied. A number of cerebral-palsied children are taught at home by public-school teachers, and teachers are also sent by the public schools to give instruction to such children in hospitals, convalescent institutions, and residential schools. Lastly, a number of children are enrolled in the public-school classes that are the subject of this ar-

ticle, namely, special classes in public schools, for cerebral-palsied children.

Each of these services may require a battery of trained personnel, in the fields of pediatrics, orthopedic surgery, physical medicine, physical therapy, psychiatry, psychology, neurology, occupational therapy, speech therapy, nursing, social work, and education, making an adequate program very costly. Small wonder that most governmental authorities have been slow to appropriate funds for many of the services necessary.

Within the past 7 years in New York City four special units for children with cerebral palsy have been developed in the public schools. The first such unit began in 1946, the second in 1950, and two were opened in 1952. Each of the four major boroughs of the city now has such a unit.

At first financial support came from voluntary agencies (the New York Service for Orthopedically Handicapped, the Association for the Ailing of Crippled Children, and United Cerebral Palsy of New York). Later the city's Department of Health and Department of Education were able to obtain funds to provide the services.

The first unit was organized as a nursery school and was housed in one of the Health Department's district health centers. Medical guidance

## ND SPECIAL CLASSES IN PUBLIC SCHOOLS

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Later the unit was moved to a public elementary school, and the other three units, financed partly by private agencies, were opened in similar schools—two classes to a unit.

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Each unit is planned for 25 children between the ages of 4 and 10 years. Personnel for each unit consists of a part-time medical director (who may be a pediatrician, an orthopedic surgeon, a physiatrist, or a neurologist), two full-time physical therapists, one full-time occupational therapist, one full-time speech therapist, one full-time attendant, two full-time teachers, one part-time psychologist, one part-time medical social worker, one part-time public-health nurse, one part-time pediatrician, and one part-time secretary. In addition, the department provides consultation in the fields of ophthalmology and otology when this is needed.

These special cerebral-palsy classes aim to provide education and health services and special therapy, for potentially educable children who are too severely handicapped physically to attend regular or orthopedic classes. The classes work to habilitate as soon as possible children who can be expected to go to regular school later. As soon as a child is able to get along in a special class for orthopedically handicapped children, he is transferred to such a class. Each of the special classes for cerebral-palsied children is established in a school that also has an orthopedic class, in order to facilitate the transfer of a cerebral-

palsied child to the orthopedic class whenever he is prepared for this.

Children are referred to the special cerebral-palsy classes by private physicians and hospital clinics, from whom a complete medical report is obtained. A screening examination is conducted at the school by all the professional personnel of the cerebral-palsy class, and a group decision is made regarding the child's trial admission, or rejection. Each child admitted attends the class for a 3-month trial period, after which the staff makes the decision. When it seems time to discharge a child, this decision also is made on a group basis by the staff. (A copy of the Manual for the Operation of Cerebral Palsy Units in New York City is available upon request to the Bureau for Handicapped Children, New York City Department of Health, 125 Worth Street, New York 13, N. Y.)

### Seven requirements listed

A child is admitted to a cerebral-palsy unit (1) if he is between 4 and 10 years of age; (2) if the diagnosis of cerebral palsy is confirmed by the medical staff of the unit; (3) if his admission is recommended by a practicing physician or a treatment agency; (4) if he lives in the borough served by the cerebral-palsy class; (5) if his handicap is too great to permit him to attend a regular or an



orthopedic class, but not so severe as to preclude the possible development of a useful degree of independence; (6) if his mentality is estimated to be normal; (7) if he seems to be ready for group participation, socially and emotionally.

A child is discharged from a unit (1) if his physical condition improves enough to qualify him for an orthopedic or a regular class; (2) if his mentality is found to be too low to permit him to benefit from the cerebral-palsy class; (3) if he does not improve physically at a rate that justifies keeping him in the class; (4) if his behavior is too disruptive to the class; (5) if his family moves out of the borough served by the school; (6) when he reaches the age of 10 years (the upper limit for eligibility at present).

#### Parents learn about child's needs

One of the important benefits of these classes comes from their relationship with the parents of the children. Parents are encouraged to participate in the day-to-day operation of the class through rotating assignments to the class on a daily basis. They may assist their own and other children with feeding, dressing, toilet care, and so forth. They also help in transporting the children to school and home again. Such participation enables parents to develop a better understanding of the children's needs so that they may carry on better at home after the school closes in the afternoon. One unit holds periodic group meetings with the parents; the discussions are conducted by staff members or other workers in the field.

What do these special school classes accomplish for cerebral-palsied children? As a partial answer to this question, here is a brief statement concerning the class that has been longest in operation. (The figures cover the period from March 1946 to June 1953.)

Of a total of 372 children for whom application was made for admission to the special class, 83 children (22 percent) were found to be eligible and 244 (65 percent) ineligible. Eight percent were referred to a similar

class in another borough, and 4 percent were awaiting screening when these figures were compiled.

Of the 83 children eligible, 65 were admitted. The other 18 were placed on a waiting list to be admitted as vacancies occurred.

The physical handicaps of the 65 children on admission were severe. Ninety percent were unable to dress themselves alone; 79 percent could not walk; 79 percent could not care for themselves at the toilet; 48 percent could not feed themselves; and 43 percent could not even sit up by themselves. It is evident that the selection of these 65 children for the special unit was appropriate, for the classes are planned to serve the very seriously disabled.

As for the 244 children not admitted to the cerebral-palsy class, the reasons were as follows: Other arrangements were made by the parents for 52; 46 of the children were not eligible on account of their residence; 40 failed to complete the tests necessary to determine eligibility; 31 children were outside the age limits; 33 were able to get along in school without the help of the special services; 31 were considered too severely handicapped for the cerebral-palsy class. For 7 children the diagnosis of cerebral palsy was not confirmed, and 4 children died before the admission procedures were completed. It is significant that by means of the screening examination 13 percent of the 244 children were able to carry on their education in regular or orthopedic classes.

During the period of stay in the class covered by this report one-third to almost one-half of the children developed the ability to do certain things essential to their carrying on as independent individuals, in marked contrast to what they could do when admitted.

Of the 65 children admitted to the unit, 38 were discharged after staying for an average of 14.9 school months, and 27 were still in attendance at the time of the report, with an average length of stay, so far, of 12.1 school months.

Fourteen of the 38 children discharged had improved sufficiently to

progress to an orthopedic class in the school within an average period of 14 school months. Eight were found to be mentally retarded; 6 were transferred to another cerebral-palsy school unit in another borough when it opened. Two children became ill and were unable to continue; 2 had such serious behavior difficulties that they could not be kept; 3 were removed by their parents; and the families of 3 moved out of the school district.

#### Physical improvement too

Apparently the children's group experience often promotes their physical habilitation. Doctors who have known the children for years remark on how rapidly a child's physical function seems to improve as he relaxes in the normal, friendly atmosphere of the class and the school. Parents, too, seem to be able to treat their own children in a more relaxed and normal way after they have been with other cerebral-palsied children. There seems to be real value for parents in helping the staff with other children as well as in seeing how a staff member handles their own child. Thus, one mother who at first rebelled at helping another child with toilet needs came to accept her own child's needs more easily, and she later said that she had gained much through helping the other child. The children's progress at home is, of course, discussed by staff members and parents.

The influence of these classes on the rest of the school has been noticeable. The cerebral-palsied children are encouraged to join in school activities such as general assemblies, and they are seen on the playgrounds. The other teachers observe the clinical approach of the staff team that works with these handicapped children. Principals have pointed out that this has helped the teachers see the children in their own classes more as individuals, and has tended to enable them to deal with problems in a more objective manner. One principal has emphasized that the presence of these very severely handicapped children in his school has helped "character building" in the other pupils, mean-

ing that they had become more tolerant of those in need and kinder to them.

#### Cost must be counted

One of the important problems to be faced in connection with such classes as these is the cost. In the school year 1952-53 the total cost for a cerebral-palsy unit accommodating 25 children was \$45,319.50 or \$1,813 per child. Of this amount the health services cost \$22,982 or about \$919 per child, and the educational service \$10,400 or \$416 per child.

The transportation to and from the school cost \$11,937.50, or \$477.50 per child.

In addition, approximately \$4,000 worth of equipment and supplies is needed in order to start such a unit. This includes such items as physical, occupational, and speech-therapy equipment; relaxation chairs; standing tables; parallel bars; and typewriters for the children.

The expenditure of \$922 per child for the health services is considerably less than that required to maintain a child for a year in a hospital (\$4,745) or in a convalescent home (\$2,920).

The \$416 per child for educational service might be compared with the cost per child of educating children in orthopedic classes (\$800) and in regular classes (\$400).

Transportation accounts for more than a fourth of the cost of the entire service for the special class.

The costs for health and education services in a unit accommodating 25 children were distributed as follows:

For health services, including special therapy: Medical supervision, \$4,800; physical therapy, \$6,520; speech therapy, \$3,260; occupational therapy, \$3,260; psychologist's services, \$1,250; medical social service, \$1,100; secretarial service, \$1,200; medical coordinator's services, \$1,500 (total, \$22,982). In addition, public-health-nursing service is provided by the Bureau of Public Health Nursing of the Department of Health, through the public-health nurse regularly assigned to the individual public

school, as part of the general school health service.

For educational services: Teaching, \$8,000; attendant service, \$2,400 (total, \$10,400).

These special classes for cerebral-palsied children represent one type of service that seems to be needed by such children.

The classes have been operated so far on an empirical basis, particularly in regard to the types and numbers of personnel necessary to staff the units. Many questions in this regard remain unanswered at the present time.

For example, we do not know if it is essential to provide both physical therapy and occupational therapy. Nor do we know if a medical social worker is necessary or how much of a psychologist's time is needed. Obviously the answers to these questions are important to the children and their parents, and to administrators responsible for planning community services for children with cerebral palsy. This kind of question will be answered, we hope, both through experience in the operation of these units and through a special research study of the functions and the time of the personnel in the classes.

#### Experimentation needed

We need also to find methods of evaluating more accurately the physical and educational growth and development of the children in special cerebral-palsy school classes. (The data presented here on the children in one class include only very gross indices of physical development and none on educational progress.)

Again, it is possible that the 4-year age level at which children are now admitted might be lowered. Experimentation in this direction is important, for it seems desirable to start the child in the special unit as early as possible.

The current program also does not meet the needs of the child over 10. At present when a child reaches the age of 10, unless he is prepared to attend a regular or an orthopedic class, he is given home instruction. It is possible that much of the progress made by the younger child in the special

class is being lost after his tenth birthday, when he is taught at home; certainly he loses the opportunity of mixing with other children. Therefore plans are now being made to provide special classes for cerebral-palsied children 11-17 years of age. These services for older children will be closely integrated with a program of vocational testing, guidance, training, and placement.

It is possible also that, by providing more adequate medical supervision and physical-therapy services for children in orthopedic classes, we can help many of the children in the cerebral-palsy classes to graduate to the orthopedic classes more quickly. Such services are now being planned.

#### What is a child worth?

The expenditure of over \$1,800 per child annually for the habilitation of the children in these special classes may be questioned. But from a long-range point of view, the fact that the classes have helped children to change from complete and permanent dependence upon society to some degree of independence and productivity is of great importance, both for the individual and for society. Furthermore, from a purely fiscal point of view, an annual expenditure of \$1,800 per child in these special school units must be compared with the annual expenditure from New York City and State tax funds of \$4,745 (at \$13 per day) for the care of such children in hospitals and residential schools, and \$2,920 (at \$8 per day) in convalescent homes.

When a cerebral-palsied child goes to a special class in a day school the family has the advantage of being able to keep him at home, while all the necessary health and educational services are provided for him. This is important, particularly from the viewpoint of the child's emotional growth and development. It is of the greatest value if one believes, as the present writers do, that insofar as possible a handicapped child should be brought up like other children, rather than with the additional handicap of living away from home. And, after all, it is the child's life that matters most.



# WHEN CHILDREN ARE CONVALESCING FROM RHEUMATIC FEVER

Parents discuss common problems with clinic staff

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**A**T OUR pediatric cardiac clinic various staff members have for a long time recognized that the parents of children who are recovering from rheumatic fever have many problems. During the acute stage of the disease the parents' concern is centered on the treatment of the illness. But after that stage has passed, and also the stage when the child is resting in bed, the parents encounter increasing difficulties. For when the doctor says that the time has come when the child may—and should—become more active, the parents are likely to worry much more than they did earlier about what may happen to their child.

Our staff members have always instructed the various parents individually, giving them as much help as possible in their efforts to care for their sick child and restore him to health. But as we all know, people gain confidence through talking together about their common problems. Acting on this idea, the physician who directs the clinic, and the medical social worker assigned to it, introduced a plan for encouraging and helping the mothers by gathering some of them together at the clinic for discussion. (At that time we had not thought of including the fathers.) This was in November of 1951.

The entire staff of the clinic—five doctors, the nurse, and the medical social worker—became a committee to plan for the parents' meetings.

At our first meeting, our planning group defined its purpose. It was to help parents understand rheumatic

fever so that they could do a better job for their convalescent children, and do it with less anxiety. We did not think of the meetings as group therapy, in the sense of uncovering and solving basic emotional problems; but we hoped that the group experience would help to reduce the parents' worries about the child's recovery.

Since our clinic was going to try the group approach as an experiment, we felt that we should limit our goals, and not let the meetings be looked upon as a cure-all for the parents' emotional problems. Nevertheless we felt that through free discussion the parents could help one another to face their common problems with less anxiety. We hoped also that we could help them with the problems by encouraging them to ask questions and by providing information.

Before the meetings could begin, which we hoped would be in 2 months, the staff had many points to settle: How many parents should be invited to join the group? How would they be selected? Who would interview them and explain the project? Who would lead the meetings? How could the discussions be recorded?

We tentatively selected the place for the parents' meetings, at the clinic, and scheduled our own planning sessions for November and December—weekly or biweekly.

Two sessions were devoted to studying criteria for selecting parents. We decided not to limit the group to mothers, for we felt that the children would benefit if the fathers participated also. This turned out to be the right decision, for we learned that although the fathers were in-

clined to think that caring for the sick child was the mothers' job, they at the same time resented being left out.

We decided that 8 to 10 parents would be a good number; a meeting of this size, we believed, would permit full discussion and free exchange of ideas.

## When do the parents most need help?

At first we intended not to specify any one stage of rheumatic fever when deciding on the children whose parents were to be asked to participate. But as our discussion went on, we realized that the meetings would be most valuable to the parents of children who were at the stage when they were being restored to activity, partial or full. We felt that during the acute stage of the disease, when the child is very ill, and at the bed-rest stage, when he is quiet, the parents are more able to cope with their problems than when the child is permitted by the doctor to be up and about.

We tried to select parents who were fairly intelligent and thus able

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to contribute to discussions, and who were not too emotionally disturbed themselves. The doctors wondered whether there was any danger that the meetings might release deeper emotional reactions than could be handled comfortably in a group; this, they felt, might defeat our plans. We were pretty sure that this could not be entirely avoided, and so we decided that if it occurred we would offer to

bility for considering his group of patients and selecting families that he thought would benefit from parent meetings. After deciding on a family, the doctor discussed its suitability either with the staff, at a regular pre-clinic conference, or individually with the medical social worker, who already knew many of the families. After a family was agreed upon as suitable, the doctor talked to the

their getting acquainted and deciding on specific points for discussion. The parents were also polled with regard to their preference concerning the times when the meetings would be held.

#### We look for common problems

The medical social worker shared what she had learned from the parents with the rest of our planning group, and we then sifted the information to discover common problems. The group learned that in a number of cases the parents somewhat distrusted the medical management; that they had difficulty in permitting their child to increase his activity, even though the doctor had ordered this; that they were uncertain and fearful as to their child's future health; and that they were worried lest the child would have problems in adjusting in school.

As a month passed and only a few parents had been decided on as group members, we began to realize that we had been too optimistic. December brought slackening of clinic attendance, as well as bad weather and staff absences, and we found it necessary to postpone starting the parents' meetings till March.

The question of leadership for the meetings was solved when the medical social worker, who had had previous experience in group work, was able to arrange to take special time from the social-service department for the project. She provided regular leadership, and two of the doctors took part in all but the first meeting.

The problem of recording the meetings was never satisfactorily solved. It was suggested that we use a tape recorder; also that the leader of the group or a parent might take notes. The latter idea was brought up at the first meeting, and one of the mothers volunteered to write minutes for the one session. After other meetings the leaders attempted to reconstruct the discussions, but were unable to do it except in a cursory way.

At last, one evening in March, at 8 o'clock, three fathers and five mothers gathered in the staff room near the clinic. They sat in comfort-



When their child is in the acute stage of rheumatic fever, the main concern of the parents is, of course, to obtain the best medical care possible, whether at home or in the hospital.

help the individual parents after the meeting was over.

The next step was taken by the doctors, each of whom took responsi-

mother to find out whether she was interested in the project. (Not all the families who were approached showed interest.) After a mother's interest was clear, the medical social worker arranged an interview, preferably with both parents, for final screening and for further explanation of the project.

During the medical social worker's interview with the parents, she studied them with regard to the selection factors we had agreed on, and she obtained an idea of some of their problems concerning their sick child. The worker explained the plans for the meetings and asked the parents what they hoped to gain from the experience. She told them that the first meeting would be devoted to

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Mrs. Igersheimer (then Miss Kiningham), Dr. Crothers, and Dr. Kugel were the discussion leaders at the parent meetings described here.

The authors are indebted to Ruth Whittemore, M.D., Director of the Pediatric Cardiac Clinic of Grace-New Haven Community Hospital, for her interest and help in carrying out this project. Dr. Whittemore is also Director of the New Haven Rheumatic Fever and Cardiac Program, under the Division of Crippled Children, Connecticut State Department of Health.

able chairs arranged in an informal circle. The parents already understood that at this meeting they would help to plan the agenda for future meetings and to make the arrangements.

No doctors were present at this first meeting; this had been agreed upon ahead of time. The medical social worker opened the meeting by suggesting that the parents introduce themselves. She then asked them to tell something about their child's experience with rheumatic fever. These statements brought up specific problems, which seemed to concern all the parents.

One typical question concerned penicillin. All the parents were interested in knowing more about this drug. They wondered why the body did not build up an immunity to it; they asked whether it affected children adversely, and if so, how. One mother said that her child had been given prophylactic doses of penicillin recently, and that she thought that this meant the child wasn't getting along as well as she had hoped, even though the doctor had told her this was not true. The other parents quickly reassured her, telling her that it was merely to prevent the child from getting more infection. The group finally decided that they would ask the doctors some of these questions at the next meeting.

The parents also mentioned problems of their children's school attendance and their behavior, and wondered if they couldn't bring these up at another meeting. Several parents said they didn't know how much excitement a child with rheumatic fever could stand, and they asked at what stage of the disease one should feel free to discipline him. They were also concerned about whether their child might be "spoiled" during the course of the illness. Opinions differed on "spoiling"; some parents felt that it was impossible not to focus special attention on the child at some time during his illness.

When the leader explained that the group would decide how frequently agreed on one-hour evening meetings, they would want to meet, and as to the time of day, the parents unanimously

Tentatively they decided on a total of four weekly meetings, deferring decision on whether to continue beyond that. On this basis, future discussion was outlined as follows: Second meeting, specific questions for the doctors in relation to medical information; third meeting, problems of management of the child's behavior; fourth meeting, summary questions.

#### Questions for the doctors

The plan to have the medical social worker find out the concerns of the individual parents ahead of time, and then to let the parents discover at the first meeting that their problems were common ones, turned out to be sound. At this meeting the absence of the doctors permitted the parents to bring out their questions about medical management without fear of jeopardizing their relationship with the clinic's medical personnel. As the staff had planned, the leader succeeded during the first meeting in directing the discussion in such a way that the possibility of having the doctors come to the next meeting was brought up by several parents.

The parents were particularly disturbed because they thought they had been told different things by different doctors. They had expressed this feeling first individually to the medical social worker in the early interviews, and later they discussed it in the meetings. At the last meeting of the series they felt secure enough to express their resentment directly to the doctors. The doctors encouraged them

to bring out into the open their feelings of bewilderment and confusion, and answered many questions. This helped the parents discover that doctors had logical reasons for handling situations differently.

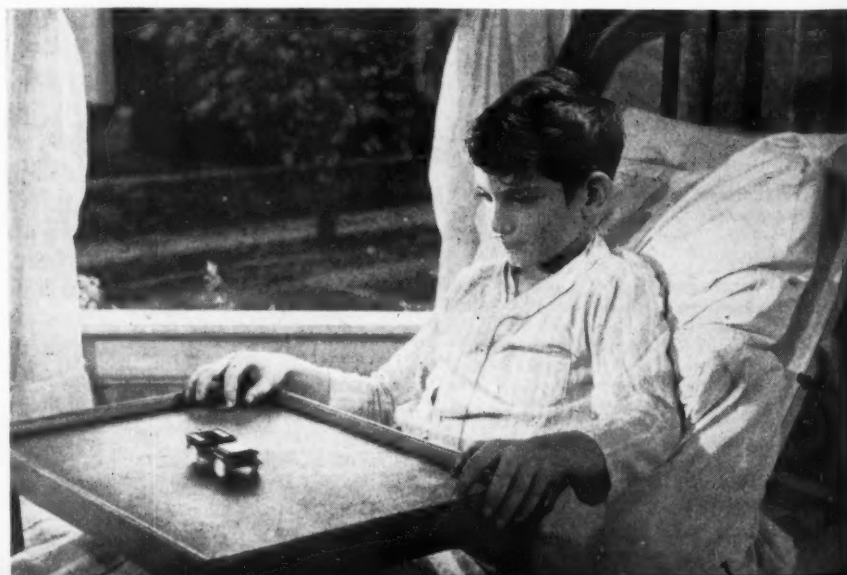
Penicillin continued to be a central theme throughout all the meetings. At first the leaders were concerned about why the parents had not asked about this earlier. Why did they need assurance now? It appeared that penicillin was symbolic of their hope for the child's recovery and future health. It would "solve everything"—it was a cure-all—there would be no more colds and therefore no recurrences of rheumatic fever!

The parents finally were able to ask the stark question: "Do you mean there is nothing I can do that I am not doing now to prevent another attack of rheumatic fever?"

This in turn led the leaders to wonder what was the effect of telling the parents that penicillin would not cure, nor prevent, rheumatic fever. Were their defenses being broken down without anything else being offered them? Did they need something tangible to do, like giving a pill? These were questions which the staff could not answer, but which certainly should be recognized in planning such group discussions.

At the last meeting, there still seemed to be some confusion in the parents' minds, but later contacts with the staff indicated that the group members had become more able to accept the limitations of treatment.

After the acute stage of rheumatic fever is past, the child must rest in bed. And it is not an easy task for parents to keep him happy, when only quiet occupations are permitted to him.





Many of the specific questions raised by the group related to the future:

One mother asked whether her little girl could have a child after she grew up, despite the fact that she had had rheumatic fever.

The entire group was concerned about whether physical exercise could cause a recurrence of rheumatic-fever attacks. Even at the last meeting it was clear that obeying the doctor's directions for increased activity by the child was a major problem to the parents. One mother admitted that every time the doctor permitted her child more activity she would reduce it by 50 percent.

#### Parents blame themselves

The parents asked how they could explain rheumatic fever to other people. This question seemed related to their own thinking that perhaps their child was "not so good." Also, did people think they were not giving good care to their child? One mother indicated that she was going to do so well in caring for her child that she would never be at fault again. It was difficult for the staff to convince the parents that they might not have been at fault the first time.

It seemed to the leaders that the parents were better able to accept the limitations of medical treatment when they realized that the fear of another attack was shared by all and that no parent would be to blame should another attack occur. Also, painful in-

formation seemed more bearable when diluted by the group discussion.

The leaders recognized that they could not remove all the parents' fears. The real situation was basically unchanged; their children continued to return to the clinic and continued to take penicillin. While this was happening the parents could not entirely accept the fact that the disease process was no longer present.

At the final meeting the parents were asked if these meetings would have been more helpful to them if they had been held during the acute period of their child's illness. The answer was: "It might have been different if you had told us this earlier." The leaders, however, wondered if this were not like talking about the last war. It was easier to talk about what they had already gone through than to deal with their present situation, such as the need to permit their children increased activity. It was clear that helping the child adjust to getting well was more difficult than helping him to accept illness.

Throughout the period of the meetings, the staff continued to meet regularly to review reports of the discussions. An evaluation of the project was made by the group leaders after the last meeting, and the medical social worker was appointed to summarize the project.

The leaders asked themselves two questions: (1) What did the parents gain from the experience? (2) What did we as staff members learn from it?

Later the doctor suggests that the child become more active. But even with the doctor's approval, many parents find it hard to permit their child such activities as riding a bicycle.

The parents had been encouraged to feel free to return to the clinic and talk with any of the leaders. It was anticipated that they might have further questions about problems the group had discussed. The two doctors who acted as leaders noted that in clinic contacts the parents seemed to carry over a changed attitude toward them. They were able to ask questions of the doctors, which they apparently could not have done previously. One value of the group then was seen in the improved doctor-patient relationship.

#### Changes in parents noted

Although the group experience seemed to reduce parent anxiety, it did not eliminate it. A month after the conclusion of the group meetings, one mother called her doctor, expressing concern because her daughter had come home from school that day after failing a test and had begun to cry. This led to nervous, jerky movements and the mother thought it might be the beginning of chorea. The staff had some reason to believe that prior to the group meetings this mother might not have been willing to call the doctor in a similar situation. Also, she now showed increased awareness of possible cause-and-effect relationships in regard to the chorea-like movements of her child.

It seemed to the leaders that the group meetings had made the hospital less formidable to the parents. They seemed more relaxed about the disease. One father bluntly stated: "I feel better about rheumatic fever." In the group the parents were able to discuss problems related to the illness, which they had not been able to do before. They seemed to feel safer in a group and to recognize that their concerns were not unique, and thus could raise questions that they would not bring up in the clinic, even when they were repeatedly seeing the same doctor. The assurance of, and through, the group was based on a kinship; they had gone through the same experience.

The leaders felt it would be impossible to measure the value the project had been to themselves as a learning experience. It gave the staff a new

(Continued on page 13)



# FOSTER PARENTS SPEAK UP

ESTHER S. MELTZER and MIRIAM WANNE

## Part 2

EDITOR'S NOTE: This is the second part of an article that began in our June-July issue. (We shall be glad to send a copy of that issue to any reader who missed part 1.)

In part 1, Miss Meltzer and Miss Wanne told how the Jewish Children's Bureau of

Cleveland began, a few years ago, to hold meetings for foster parents, with the agency welcoming the foster parents' participation in planning. Part 1, which described the first 3 months of the program, ended with the close of the first series of meetings, at the beginning of the summer-vacation period.

How the foster parents had summed these meetings up for themselves we did not as yet know. Our analysis of the first part of our venture, however, could be made with some certainty as to where we had come and what our direction should be.

First, approximately 25 to 30 foster parents had attended each meeting, the majority coming to all three. This, out of a total number of 42 paid foster homes, we considered good. Therefore, we could assume that these foster parents had questions and were seeking answers.

Secondly, the large number of questions raised indicated that we had succeeded in creating an atmosphere in which everyone felt free to ask questions, to raise problems, and to express criticism.

Thirdly, the emphasis, in committee meetings and in group meetings, on the fact that our purpose was to examine together the whys and wherefores of placement became the basis of a new understanding. On this basis the group began to realize that criticism of each other and of ourselves could be helpful, and was necessary if our work was to continue to improve, and that there were no specific answers to the specific questions asked.

Fourthly, the concept of "the agency" began to change. Both the staff and the foster parents began to recognize that *we together* are the agency.

This last point was important not only in relation to the foster parents. These first three meetings had served

to stimulate rethinking by the professional staff about the questions: (1) Why do people become foster parents? and (2) what is the relationship of foster parents to the agency? Our work with foster parents during these 3 months began imperceptibly to change. The foster parents were slowly emerging from the status of quasi-client into the position of fellow worker in a common task, a concept long a part of agency thinking, but now reflected in practice to a degree not known before.

### A main topic chosen

The fall of 1948 saw the beginning of the second period of our meetings with foster parents. Analyzing results of the first three general meetings, the planning committee voiced appreciation for the opportunity the meetings had offered for the foster parents to get to know one another and to share experiences. It was helpful to know that their questions and their problems were not unique—not faced by each of them alone. There was a note of vague dissatisfaction, however, in their comments about the fact that the discussions wandered so. They thought it would be more helpful if the meetings were centered around one major subject of discussion.

As this possibility was explored, it became clear that one source of general and major concern was the adolescent foster child. Therefore "Adolescents in placement" was agreed upon as the over-all subject for the current series of meetings.

The group felt that it would be important that we give consideration to how we can help the adolescent foster child grow into independent, responsible adulthood.

What is the agency's role in achieving this aim? What is the foster parents' role? What is the child's?

How can we help the youngster with the task of earning, saving, and spending money?

What is the place of the home and of the school in disciplining the child?

How do we give sound sex information to the adolescent?

And, finally, as a separate topic: What are the special needs, if any, of the displaced European foster child?

In this committee meeting we thought there was complete agreement on the program we were to follow for the year, and in the first general meeting we inaugurated our discussion. The second meeting of the planning committee, however, saw a vehement outburst of pent-up feelings. The attack was led by Mrs. Hart. She, for one, got nothing out of the meetings and thought them a waste of time. Mr. Robins complained that he had come to meeting after meeting expecting answers to his questions, but all he got in reply was more questions. His wife vehemently declared that she wanted us all to know that she, for one, felt she was a complete failure as a foster mother because she had not been able to bring about changes in her foster child.

The storm raged, while every member of the committee added his gust of anger and frustration. The staff representatives, during two lulls, remarked that it was up to this committee to determine what kind of meetings they wanted. If these were not satisfactory, we could plan others according to their suggestions. We were not meeting in order to have the foster parents prove they are good foster parents; this they have done, and do, in their everyday work with the children. What we want and seek from the meetings, we said, is an exchange of experiences so that we can learn from one another. Perhaps there are no specific answers, and perhaps there cannot be any.

The storm died down. Mrs. Hart reflectively commented: "The won-

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derful thing about these committee meetings and the large meetings is that you get things off your chest and then feel so much better. It's just like a psychiatrist's office."

Perhaps Mrs. Hart was not so very wrong in her analogy. In our staff analysis of this committee meeting we recognized that what we had expected and hoped would come, indeed had come, and perhaps earlier than we had anticipated. The outburst in the committee meeting had really cleared the air.

Our method had been to raise questions and to encourage free discussion in reply. As a result, the foster parents had brought to the surface many feelings of frustration, including some of the very frustrations that had led them to become foster parents in the first place. The consequent anxiety had to be dispelled before the group could advance unhampered by personal conflict and emotions. The therapeutic value of the outburst was proved by the rapid coordinated strides that were made in all the meetings that followed.

In the second general meeting of this period, the discussion leader spoke of the reactions of the planning committee and encouraged the group as a whole to give critical consideration to our meetings. One after another, the foster parents stated that they had not been satisfied with the meetings to date. They wanted specific answers, and, more than that, an answer to the question: "Why can't we have specific answers?" The caseworkers at this point spoke in a more personal vein of the feelings of frustration we so often experience in our own work with children and their parents.

We stated that we did not ourselves have all the answers. We knew some things about child care that we had learned from the long line of workers preceding us. We had some answers gleaned from other fields of work, like medicine, history, sociology, psychiatry. And we had still other answers from our own personal work experiences. But whether these answers were *the* answers, we could not and would not say. Our purpose in these meetings was to seek answers

together and to admit, if necessary, that we did not have the answers to every question and that it might not be necessary to have a specific answer to each question.

These two fall meetings constituted the crisis and the turning point of our program. Having expressed a sense of frustration, having given vent to an outraged feeling of failure, the group began to evidence a change of attitude. Their interest was sharpened; there was less insistence on "specific" answers; attendance remained at a high level. The increased freedom with which foster parents shared their experiences and reactions, the ease with which they began to challenge one another and staff was exciting. We felt that for both foster parents and staff the purpose and vitality of these discussions were clear.

#### We change our meeting place

It was interesting that the same dynamics that had been so potent in the planning committee were operative in the large group, and with the same over-all results. There was, in the meetings that followed, a more businesslike air. There were fewer side discussions, and more consideration was given to each member of the group as he presented his point of view. It was with alacrity that the group accepted the suggestion that future meetings be held in the agency's downtown office instead of in the homes of various staff members. And the wonder in their comment, "You mean this is where your staff has its meetings?" marked another step in the direction of higher status as recognized members of the agency's staff. There were repeated references to the general meetings as "our meetings" and to the planning committee as "the board."

The personalities were etched as sharply as before, but all participated in each meeting with more objectivity and with a desire to get the maximum from every discussion.

From January through May 1949, the following topics were discussed in the general meetings:

- 1 What is the meaning that going to work has for the adolescent

foster child, whether it be full-time or part-time work?

- 2 How can we help the adolescent learn to manage his earnings responsibly? In this discussion the group voiced sharp criticism of the agency's policies on allowances and savings plans; and the next meeting saw the establishment of a joint committee of five foster parents and two agency staff workers to study the financial planning for the children and to make recommendations for changes and improvements.
- 3 How is an adolescent foster child prepared for placement and how does the caseworker help him understand his own responsibilities as a member of a foster family? This discussion was based on material presented by a panel of two caseworkers and two foster parents.
- 4 Is there a difference in what may be expected of a child who grows into adolescence in a foster family and one who comes into a foster family at adolescence? Two foster mothers told us of their experiences with such children. In this meeting the matter of sex education was gingerly touched upon. The group felt that the whole matter of sex information and of the feelings that children and adults have about it should be left for "our course" next year on the younger child.
- 5 What were the recommendations of the financial planning committee? The report, given in two meetings, showed careful and critical scrutiny of the agency's plan of allowances as it related to the needs of children of the different age groups and their ability to take responsibility for the management of funds. For instance, the group challenged the agency's expecting a 6-year-old to set aside 5 cents a week to purchase a toothbrush periodically. At the same time they recommended that the allowance for the 16- to 18-year-old should

include 25 cents a week for dry-cleaning and 35 cents a week for haircuts. They did not feel that planning for shoe repairs should be left to the adolescent because this was an area of less concern to the adolescent and one, if neglected too long, would require additional expenditure by the agency. When the recommendations of the foster parents' finance committee was submitted to the agency board and became agency policy, another milestone in the foster parents' new-found status was passed.

6 The final discussion was on the displaced child.

#### Questions:

Why do foster parents choose to offer their homes to a European child?

Is the displaced child different from the American child, and if so, how, to what degree, and why?

Is treatment of him different from that given the American child? Or should it be? What are the differences in cultural background and how do they affect the child's adjustment to America?

What has the agency learned about the displaced child and can it apply that learning to the American child's needs?

What did these children expect from America, what did they find, and how did expectations and findings affect their behavior in the foster home?

A dinner meeting, held on the grounds of our institution, marked the end of this series of meetings. The program was planned by a joint committee of foster parents and staff. A member of our board and the Director of the Jewish Welfare Federation were present and addressed the group briefly. The rest of the evening was spent in informal parlor games involving everyone present.

Since then the annual dinner meeting has become a tradition to mark the end of each series of meetings. The genuine warmth and respect of the group members for one another, along with the plain good fun that characterizes that social affair gives us all a deeper understanding of the kind of people the foster parents are.

The summer months gave us an opportunity to gain some perspective on our foster parents' discussion program, to attempt critical scrutiny of what had been accomplished, and to

give consideration to what the future program should be. To be critically objective about something as vital, dynamic, and challenging as these meetings had been was not easy. Staff enthusiasm was untouched by the amount of time, thought, and energy that these meetings demanded.

It was clear to everyone that what was accomplished in these meetings could never be done in a person-to-person contact in individual situations. It was agreed that perhaps the most important purpose served by these meetings was the group feeling that had developed, and the recognition that had come to each of the foster parents of his role within the agency. All of us—foster parents and staff alike—were beginning to recognize a certain universality in the problems and reactions involved in foster parenthood. Foster parents and staff members alike began to recognize the uniqueness of their own special function. Foster parents were beginning to be recognized as the "experts" in the 24-hour day-to-day living with children, and caseworkers as the "experts" in the over-all knowledge of child development. The importance of mutual interchange became clearer to both.

#### What about the natural parents?

The staff recognized that a continuation of the program would involve further self-scrutiny and self-criticism. The way would be long and difficult for both worker and foster parent, because criticism is painful and the line between the destructive and the constructive is tenuous. But there was no question in the minds of staff as to the importance of continuing the discussions.

In the individual contact of worker and foster parent it would be difficult to say who was the more eager to apply the points that had been made. Each of our workers can tell of the foster parent's renewed desire to tackle the needs of the, more emotionally deprived youngster, and of the worker's renewed confidence that this could be done jointly.

In setting up their discussion program for the third year, the foster

parents were still concerned with problems that make foster parents anxious. In choosing for their main topic of discussion, "The natural parents of the foster child," they were involved at first with the disturbing effect on a foster child of contact with his own parents, and with the resultant reaction on them as his foster parents. From a worker's presentation of the story of a family, the foster parents gained some understanding of what is involved for natural parents as well as for the children when it becomes necessary to seek foster-family care.

Perhaps a comment by one of the foster fathers will best illustrate what happened to many of the group. He said: "I used to think the agency shouldn't make it so easy for parents to place a child. I thought it was like taking off an overcoat and saying, 'Here, take care of it,' but I see it isn't so easy."

As the foster parents reluctantly and painfully permitted themselves to identify with the "own" parents, they also discussed their own feelings. They again tested out, and accepted, the freedom to talk about themselves. But certainly they were moving slowly toward understanding better a foster child's relationships outside of the foster home.

In their discussion of "frustrations"—the topic chosen for the third year—the foster parents considered all their experiences with the foster children which made them as parents feel frustrated. They found these frustrations in the foster child's behavior and reactions; in the accommodations they had to make in their own routines and family plans; in the existence of the foster children's own parents; in the foster child's relationship to their own children; in the uncertain and temporary nature of their relationship with the foster child; and in the limitations at times imposed by the agency policies. (This last was still to a great extent represented in the person of the caseworker.) In all this they were primarily concerned with their own discomforts. At the same time, however, they expressed some understanding of these frustrations as in-

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herent in caring for a foster child. There appeared to be some further progress toward regarding their service as a defined job, with satisfactions, but also with problems that require adjustments in the performance of this job.

It was during this third year that many of the foster parents began to participate actively and effectively on a foster-home recruiting committee headed by a staff member. They derived real gratification from their feeling of status with the agency and in the community. It has been interesting to note that recent applicants for foster children have spoken of their interest in the agency's foster-parent discussion group.

#### Questions seem inexhaustible

The fourth year was devoted to a discussion of the relationship of foster parents to the agency: What are the qualifications for foster parenthood? To what extent are foster parents expected to modify their way of life and standards of behavior in order to accommodate the needs of the child? What are the agency's expectations of the foster parents in relationship to the child's own parents? And so forth.

The fifth year, just ending as this is being written, concerned itself with the following specific topics:

1. What is the relationship between the foster parents' own children and the foster child?
2. What responsibility does the agency carry for religious education, and what is the foster parents' part in this?
3. What is the role of the foster parents in sex education? (Three meetings were devoted to discussion of this topic.)
4. What is the attitude of the community toward foster parents and foster children?

During the 5 years that our monthly foster-parent meetings have been in progress, several things have become clear:

There has been a minimal turnover in placements.

Foster parents seem to be bringing to the job of foster parenthood the same attitude toward success and failure as do the rest of the staff; that is, there has developed an increasing reluctance to admit inability to care for a particular child.

There has been increased interest

in serving the difficult child and much greater involvement in cooperative planning with the caseworker in meeting special needs of various children.

There is greater identification with the agency as a whole and a clearer understanding of the foster parent's specific role.

The hitherto unobtrusive foster father has been drawn into active participation, not only in the group discussions but in the actual work with the foster child.

Word concerning our foster-parent meetings has permeated the community. This has been brought to our attention by foster-parent applicants who often refer to our meetings as one of the reasons why they would like to be a part of our agency's program.

We are finding, too, that foster-parent applicants have a much clearer conception of what is involved in foster parenthood than they did in the past. This, we believe, is a reflection of the community interpretation inherent in our foster-parent meetings and in our foster-home recruitment program, which is an integral part of our current agency program.

The status that foster parenthood has been gaining as far as the participating foster parents are concerned, has been manifold. One of our foster parents has written an article on what it means to be a foster parent, which has been published and reprinted for distribution by the Child Welfare League of America. This same foster parent has participated in panel discussions on foster parenthood held at conferences in Columbus and in Detroit. One of our foster fathers has drawn the pictures for a foster-home recruitment pamphlet which is being used community-wide by local child-placement agencies. Two of our foster mothers are actively involved in our foster-home recruitment program. Joint foster-parent and staff committees continue to reevaluate specific phases of the agency program. Our monthly foster-parent meetings are recognized by foster parents and staff as an inherent and indispensable part of our foster-home program.

## RHEUMATIC FEVER

(Continued from page 9)

understanding of the meaning of illness as a family experienced it. It was an eye-opener to become aware of parents' questions and attitudes that seldom would come to light during clinic visits. The planning group found it valuable to observe how a group approach could help families in adjusting to the child's illness.

A great deal was learned about team relationship through the process of working and planning together. This process carried through even in writing up the project. It was clear that the preliminary planning had been extremely important. The purpose of the project needed to be accepted and understood by the total group. This had to be a gradual process. Even with extensive planning, improper selection of parents could have defeated the goals of the project, since discussion depended on having a fairly homogeneous group. There was a feeling of purposefulness about the meetings and there was good group solidarity from the beginning.

The project demonstrated to the participants that there was value in having group meetings for parents of children with rheumatic fever. The planning group did not consider the results conclusive since tangible benefits for the parents could not clearly be defined. The experience, however, provided the staff with an opportunity to observe the potentials of the group approach as one way of helping families in their adjustment to the child's illness. The knowledge that the participants gained about parent attitudes, the opportunity the meetings provided to observe group interactions among the parents and their attitudes toward the clinic staff, the personal experiencing of the group process within the planning group, were unexpected by-products of the project. In retrospect, we see that the educational value to the staff may have exceeded the educational and therapeutic values for the parents.

This experiment has provided a basis for further study of the value to parents of group experiences in a rheumatic-fever program.

## FOR YOUR BOOKSHELF

**THE GROWTH AND DEVELOPMENT OF THE NEGRO IN DENTISTRY IN THE UNITED STATES.** By Clifton Orrin Dummett. National Dental Association. The Stanek Press, Chicago, Ill. 1952. 124 pp. \$5.

It was a quarter of a century after the first dental school in the United States began its sessions that Robert Tanner Freeman, the first Negro in this country to receive a formal education in dentistry, graduated from Harvard University's School of Dental Medicine (1867). Since then, the author tells us, this school has graduated 25 Negroes, but the efforts of Negroes on the whole to gain opportunities for basic and dental education have met with much difficulty.

The book gives data on the ratio of Negro dentists to the Negro population at different periods from 1890 to 1940, and other important information, such as percentage increases and decreases of Negro dentists in various regions of the United States.

One chapter reports on a recent study of interracial professional practices and attitudes of Negro dentists in a Southern city.

While offering an interesting history of the Negro in the dental profession, this book also contributes to the literature on the development of dentistry as a whole in this country.

John T. Fulton, D.D.S.

**HOME FINDING;** the placement of children in families. By Gladys Denison Day. Federal Security Agency, Social Security Administration, Children's Bureau, Washington, 1951. Processed. 67 pp. Single copies free at Children's Bureau.

"Perhaps we can do a better job of planning new ways in the future if we spend a little time in looking at the mistakes we have made in the past." In these words the author shows her purpose in writing this objective appraisal of the social agencies' success, or failure, in finding foster homes for children.

"As social workers," she says, "we have failed to let the community know what we were doing and learning. A very small proportion of the public ever heard of foster-home care before the campaigns of recent years, and many people still know little if anything about it. This lack of information is largely the fault of professional workers who

have thought it possible to exist in isolation from the community."

The author discusses campaigns for finding couples who are likely to be suitable foster parents; study of foster homes; cooperative planning between the agency and the foster parent for the good of the child; and educational work with foster parents in groups. She also presents sample letters from an agency to foster parents.

Since the booklet is not intended to be a comprehensive study of the child-placing field, adoption families and independent boarding homes are not discussed; nor is casework with children in foster homes except as it affects parents.

Mrs. Day bases her study on long experience in child placing. She has been on the staff of the Children's Service Society of Wisconsin, the Chicago Child Care Association, and the Board of Public Welfare of the District of Columbia.

I. Evelyn Smith

## IN THE NEWS

**Rheumatic fever.** The Board of Trustees of La Rabida Sanitarium, Chicago, announces the inauguration of an annual institute in the field of rheumatic fever. The institute will be held for the first time on October 12, this year, and thereafter on that date or the first Monday that follows October 12.

The institute will be educational in character and will cover the subject of rheumatic fever and rheumatic heart disease. It will be conducted for 4 days by members of the hospital staff, together with others selected from the medical schools with which the hospital is affiliated, and by several invited guests. It will be directed primarily to the general practitioner or family physician, and to nurses, medical social workers, occupational therapists, dentists, and others with a similar interest in the subject. There will also be a scientific session. Sessions will be provided also for the public, especially patients and their parents.

Advance registration will be required for those who wish to attend the entire 5-day session. Attendance will be open to all these groups and will be limited only by the size of the building to accommodate those who attend. Visitors to individual sessions will be admitted by card on previous application. There will be no admission or tuition charge.

Further information will be supplied by circular, on application to Institute, La Rabida Sanitarium, East 65th Street and South Shore Drive, Chicago 39, Ill.

**Midcentury Committee.** On July 1, 1953, the National Midcentury Committee for Children and Youth, which was formed late in 1950 to advance the findings of the Midcentury White House Conference, was dissolved.

Inquiries formerly directed to Leonard Mayo at 580 Fifth Avenue, New York City, should henceforth be directed to Dr. Katherine Bain, Acting Secretary, Interdepartmental Committee on Children and Youth, Children's Bureau, Department of Health, Education, and Welfare, Washington 25, D. C., or to Robert E. Bondy, Chairman of the Council of National Organizations for Children and Youth, 345 East 46th Street, New York 17, N. Y., or to Douglas H. MacNeil, Secretary, Council on State and Local Action, 222 West Main Street, Trenton, N. J.

**Juvenile courts.** A revision of juvenile-court standards to put more emphasis on the legal rights of children and their parents is being prepared jointly by the Children's Bureau, Department of Health, Education, and Welfare, and the National Probation and Parole Association.

As a part of the preparation of the revised standards, a group of some 30 experts in juvenile-court proceedings spent 3 days in Washington (June 17, 18, 19) going over a draft of revised standards. The experts included juvenile-court judges, probation officers, directors of voluntary and public welfare agencies, and lawyers.

The only previous formal statement of juvenile-court standards was issued in 1923—also made jointly by the Children's Bureau and the National Probation and Parole Association.

The revision will take into consideration not only the suggestions of those attending the conference, but also the suggestions of approximately 200 other persons who are leaders in the fields of law and child welfare.

The conference was presided over by Judge Edith Cockrill of the Juvenile Court of the District of Columbia. Karl Holton, Chief Probation Officer of Los Angeles County, California, was co-chairman.

The revision of the juvenile-court standards is a part of a larger program of the Children's Bureau to define good treatment practices in dealing with juvenile delinquency, for the use of professional groups. In process



of preparation also is a set of standards for training schools for delinquent children (no such document now exists), standards for police services to juveniles, guides to training of personnel who work with juveniles, and suggestions for State legislation on organization and coordination of services to delinquent children.

The program also contemplates preparation of information for the general public on certain aspects of the delinquency problem. Some of the pamphlets in this series already have been issued.

As drafted, the juvenile-court standards discuss the jurisdiction of the court, its procedures, the disposition of cases, court facilities and personnel, administration, records and plant, and the court's role in the community.

**Mental Health.** The Mental Health Materials Center, Inc., a new organization established for the purpose of developing new audiences and new distribution techniques for educational materials in the fields of mental health, family life, and human relations recently began operations with the aid of funds from the Grant Foundation.

According to its president, Walter Woodward, M.D., the Center's primary objective is to help the many organizations producing mental-health and family-life educational materials—printed and audiovisual—to reach new and larger audiences.

For further information address the Mental Health Materials Center, Inc., 1790 Broadway, Room 713, New York 19, N. Y.

**Juvenile delinquency.** A new Nationwide organization to combat delinquency was formed in June through a merger of the National Association of Training Schools and the National Conference of Juvenile Agencies. The new organization, named the National Association of Training Schools and Juvenile Agencies, will provide a vehicle through which all persons interested in group care of delinquent children can work to improve such care. Temporary headquarters is at Glen Mills Schools in Glen Mills, Pa. Raphael Farrell of the State Training School for Boys, Red Wing, Minn., is president of the new organization.

**Cerebral palsy.** "In a broad sense, a community effort" is the way the College of Physicians and Surgeons, Columbia University, describes the post-graduate course in cerebral palsy that it is offering this fall for physicians and occupational and physical therapists, under the sponsorship of the

Coordinating Council for Cerebral Palsy in New York City, Inc., and United Cerebral Palsy, Inc. For physicians the course covers 2 weeks; for therapists, 2 months. The opening date is October 12.

The course is designed (1) to acquaint potential leaders in this field with the basic knowledge concerning cerebral palsy; (2) to review the present status of practical therapy, including the medical, social, educational, and psychological aspects; and (3) to point out controversial features.

Cerebral-palsy centers in the New York area will cooperate.

For further information address Office of the Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 32, N. Y.

### C. B. PUBLICATIONS AVAILABLE

Single copies of the following publications may be had without charge by writing to the Children's Bureau.

The Children's Bureau Bookshelf; a book list for parents. Pub. 304. Revised 1953.

Children With Impaired Hearing; an audiologic perspective. By William G. Hardy. Pub. 326. 1952.

Emotional Problems Associated With Handicapping Conditions in Children. Pub. 336. 1952.

Children Living in Their Own Homes; social services provided through child-welfare programs. By Annie Lee Davis. Pub. 339. 1953.

Some Facts About Juvenile Delinquency. Pub. 340. 1953.

Helping Delinquent Children. Pub. 341. 1953.

What's Happening to Delinquent Children in Your Town? a guide for securing facts about certain agencies serving delinquent children. Pub. 342. 1953.

The Child With Epilepsy. Folder No. 35. 1952.

The Child With a Cleft Palate. Folder No. 37. 1953.

Services for Crippled Children. Folder 38. 1952.

The Preschool Child Who is Blind. Folder 39. 1953.

Better Health for School-age Children. Issued jointly by the Children's Bureau, the Public Health Service, and the Office of Education. 1951.

Recommended Standards for Services for Delinquent Children. 1953.

Residential Treatment Centers for Emotionally Disturbed Children; a listing. 1952.

One in Three Hundred Children Served by the Crippled Children's

Program in 1948. Statistical Series No. 10. 1951.

The Crippled Children's Program; who are the children served? Statistical Series No. 11. 1953.

Personnel in Public Child Welfare Programs, 1951. Statistical Series No. 13. 1952.

## CALENDAR

Oct. 1-4. Rural Youth of the U. S. A. Conference. 9th annual meeting. Bloomington, Ill.

Oct. 1-5. National Conference of Catholic Charities. 39th annual meeting. St. Louis, Mo.

Oct. 1-31. Red Feather Month. Information from Community Chests and Councils of America, 345 East 46th Street, New York 17, N. Y.

Oct. 6-9. American Academy of Pediatrics. 22d annual meeting. Miami, Fla.

Oct. 8-9. American Council on Education. 36th annual meeting. Washington, D. C.

Oct. 12-17. Seventh International Pediatrics Congress. Havana, Cuba.

Oct. 18-21. Girl Scouts of the United States of America. 32d national convention (biennial). Cincinnati, Ohio.

Oct. 19-22. National League to Promote School Attendance. 39th annual convention. Washington, D. C.

Oct. 19-23. National Safety Council. 41st National Safety Congress and Exposition. Chicago, Ill.

Oct. 24. United Nations Day.

Oct. 28-30. National Legal Aid Conference. 31st annual meeting. Washington, D. C.

Oct. 28-31. National Association for Nursery Education. Biennial conference. Minneapolis, Minn.

Oct. 30-31. American Academy for Cerebral Palsy. 7th annual meeting. Fort Worth, Tex.

Oct. 31-Nov. 2. National Association for Mental Health. 3d annual meeting. Cleveland, Ohio.

### Illustrations:

Cover, Philip Bonn.

Pp. 2 and 3, Lisel Lowen.

Pp. 7 and 8, Virginia State Department of Health.

P. 9, Esther Bubley.

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# THE CHILD

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### U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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